Virginia Department of Medical Assistance Services

DMAS 421A Hospice Enrollment /Disenrollment Form

Provider Name:_____	Contact Person: _____
Provider NPI: _____	Phone Number:_____
Enrolled in ☐ FFS ☐ CCC Plus Health Plan	FAX Number: _____
Health Plan Name:_____	Date Submitted: __ __/ __ __ / __ __ __ __

Fee-For-Service (FFS): For individuals who are in FFS, the hospice provider must: 1. Enter the admission or discharge into the LTC portal. 2. Complete this form and retain it in the individual's record with the DMAS 420 form.

Commonwealth Coordinated Care Plus (CCC Plus): For individuals who are enrolled in CCC Plus, the hospice provider must: 1. Complete this form. 2. FAX this form to the appropriate Health Plan for admission and discharge 3. Retain this form in the individual's record.

If hospice is provided in a nursing facility, the nursing facility must complete the DMAS 95 PASRR Level 1 form and send the DMAS 80 to the Health Plan. No entry in LTC portal is needed for enrollment in NF if enrolled in Hospice.

Please complete one form per individual. Maintain this form in the individual's record and print legibly.

For each enrollment	COMPLETE #1-6
For disenrollment/revocation/termination	COMPLETE #1-2 and #7-8 .

1. Individual Name: _____

2. Individual Medicaid Number: _____
   (Required- Do Not submit this enrollment if you do not have an active Medicaid number for the individual)

Enrollments: Complete this section for enrollments only

3. Date individual/representative signed hospice election: __ __/ __ __ / __ __ __ __

4. Date Attending Physician signed DMAS 420: _____
   (*If individual is re-electing their hospice benefit, attending physician does not need to sign DMAS 420)*

5. Date Hospice Medical Director signed DMAS 420: __ __/ __ __ / __ __ __ __

6. Change in hospice providers? ☐ Yes ☐ No

Disenrollments: Complete this section for disenrollment's only

7. Date of hospice disenrollment/revocation/termination: __ __/ __ __ / __ __ __ __

8. Reason for disenrollment/revocation/termination: _____

I certify that the Information contained herein is representative of the individual's status as documented in the individual's record.

Signature of individual completing form _____ Date __ __ / __ __ / __ __ __ __

CONFIDENTIAL-CONTAINS PATIENT IDENTIFIABLE INFORMATION

State and Federal laws prohibit misuse or disclosure of this information. If you have received this communication in error, please notify the sender listed above immediately.

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Instructions on completing the form

Demographic Box:

a. Enter the Provider name and NPI #
b. Check correct box defining Medicaid program individual is enrolled in. If enrolled in CCC Plus, enter the MCO name.
c. Enter the Hospice provider's contact name, phone number, fax number and date the 421a was submitted to Health Plan

Complete this section on all forms

1. Enter the individual's name
2. Enter the individual's Medicaid number

Complete this section only if enrolling an individual

3. The date that the individual or their representative signed the Hospice election date
4. Enter the date the physician signed the 420
5. Enter the date Medical Director signed the DMAS 420
6. Enter the correct response to if the individual has changed Hospice providers (yes or no)

Complete this section only if disenrolling an individual

7. Enter the date of disenrollment, revocation, or termination
8. Enter the reason for disenrollment

Complete the Attestation Box

Enter a legible signature of the individual completing the form
Enter the date the signature was signed.